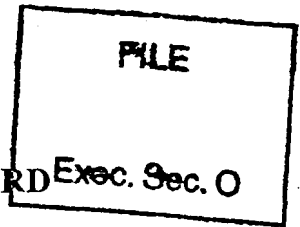


UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
SEVENTH REGION



OAKWOOD HEALTHCARE, INC.¹

Employer

and

CASE 7-RC-22141

**INTERNATIONAL UNION, UNITED AUTOMOBILE,
AEROSPACE AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA (UAW), AFL-CIO**

Petitioner

APPEARANCES:

William M. Thacker and Claire S. Harrison, Attorneys, of Ann Arbor, Michigan,
for the Employer.

Blair Simmons, Attorney, of Detroit, Michigan, for the Petitioner.

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, hereinafter referred to as the Act, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record² in this proceeding, the undersigned finds:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.³

¹ The name of the Employer appears as amended at the hearing.

² The parties submitted briefs, which were carefully considered.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The labor organization involved claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

The Employer, Oakwood Healthcare, Inc. (OHI) owns and operates a large network of hospitals and related health care enterprises. Its Oakwood Healthcare System (OHS) operates four acute-care hospitals⁴; neighborhood and occupational health care centers; specialty care centers for mammography, cardiac rehabilitation, sports medicine, and adolescent health; numerous foundations; and various ancillary services such as laboratories and pharmacies. The Petitioner seeks to represent a unit of approximately 220 registered nurses (RNs) employed at a single acute-care hospital, Heritage.

There is no history of collective bargaining among the acute-care hospital nurses at issue. However, in 1994 the Region, in Case 7-RC-20261 filed by the Michigan Nurses Association, conducted a single-facility representation election, and in 1995 a rerun election, among nurses at Heritage. The Michigan Nurses Association lost that election and a certification of results of election issues. For many years, OHMC's service and maintenance employees have been represented in a single unit by the American Federation of State, County, and Municipal Employees, AFL-CIO, and OHMC's licensed practical nurses have been represented in a single unit by the Licensed Practical Nurses League. Since 1967, the service and maintenance employees of Annapolis, Heritage, and Seaway have

³ The hearing was closed pending the receipt of Employer Exhibit 17, a comparison of hours worked by each employee overall and as a charge nurse. This document was received on January 15, 2002. Petitioner subsequently asserted by letter that the document is incomplete, as certain individuals are not included on the list. The Employer responded to Petitioner's letter asserting that certain of the employees listed by Petitioner were omitted as they are confidential employees, and for other reasons. The Employer's Exhibit 17 is not being accepted as a complete list of all employees, nor is the issue of whether certain employees are confidential being decided at this time, as no evidence was presented as to this issue at the hearing. Any disputes over the eligibility of certain employees can be handled by the challenge procedure at election. Exhibit 17 is admitted to the extent it shows on average the frequency that staff nurses may work as charge nurses. Petitioner asserted by letter that assuming Exhibit 17 is used only for this purpose, it has no objection. The document is received, and the record is closed.

⁴ The hospitals include Oakwood Heritage Hospital (Heritage); Oakwood Hospital and Medical Center (OHMC); Oakwood Annapolis Hospital (Annapolis); and Oakwood Seaway Hospital (Seaway).

been represented by Local 79, Service Employees International Union, AFL-CIO (hereinafter Local 79) in a multi-facility unit.

In 1999, Local 79 filed a petition in Case 7-RC-21970 to represent RNs at Annapolis. A hearing was held over the issue of whether a single facility unit was appropriate, or whether the only appropriate unit would be a system-wide unit of all registered nurses at Annapolis, Heritage, OHMC, and Seaway. A decision issued on May 9, 2001, wherein the undersigned found that a single facility unit, consisting only of RNs at Annapolis, was appropriate. The Employer filed a request for review, but Local 79 withdrew its petition before any decision by the Board. In the current case, the hearing officer took administrative notice of the entire record in the previous cases.

The Employer raises two issues in this matter. First, the Employer contends, as it did in Case 7-RC-21970 with respect to Annapolis, that a single-facility unit at Heritage is inappropriate, and that the only appropriate unit is a system-wide unit of all RNs at Heritage, Annapolis, OHMC, and Seaway. The parties stipulated that there are no material differences between Heritage and Annapolis as to the evidence regarding the appropriateness of a multi-site unit, and incorporated the record from the prior proceeding in 7-RC-21970 and 7-RC-20261 as the basis for determination in the instant matter.

Second, the Employer contends that the proposed bargaining unit is inappropriate because the RNs (referred to as staff nurses) sought by the Petitioner are supervisors within the meaning of the Act. The Employer submits that the primary indicia that the RNs are supervisors is their responsibility when serving as charge nurses to assign and direct other nurses, and adjust grievances.

OHI's president and chief executive officer is Gerald D. Fitzgerald. Directly under him is Joseph Diederich, the chief operating officer, who has overall responsibility for health care delivery at the four acute-care hospitals as well as numerous ambulatory, long-term care, and care management facilities and foundations. Due to the complicated series of transactions by which OHI acquired Annapolis, Heritage, and Seaway, those three acute-care hospitals are still nominally owned by a separate subsidiary corporation, Oakwood United Hospitals, Inc. However, OHI manages those hospitals, leases their real property and physical assets, and employs their staffs. In contrast to the situation prevailing at the time of the 1994 Heritage decision and election, Oakwood United Hospitals, Inc. no longer maintains a separate board or management structure.

Of the four acute-care hospitals, OHMC, by far the largest facility, offers the widest range of services, including, but not limited to, in-patient mental health, obstetrics, specialized cardiac care, neurosurgery, neonatal intensive care, cancer

center, and pediatrics. Neither Annapolis nor Heritage offers obstetrics, and Heritage does not offer pediatric services. Heritage, alone among the four hospitals, has a pain clinic, sleep lab, and in-patient rehabilitation unit. Although each hospital operates its own laboratory to perform emergency tests requiring a result in two hours or less, all routine lab tests are performed at OHMC. OHI supports its hospitals and network health care facilities with centrally handled materials management, laundry, patient billing, medical transcription, accounting, payroll, marketing, public relations, human resources, and risk management services. Each of the acute-care hospitals runs its own kitchen, but certain basic foodstuffs such as gravies and soups are prepared at OHMC and then distributed. All OHI job candidates and employees are tracked in a system-wide computer database called PeopleSoft.

Heritage Hospital is an acute care hospital with 257 licensed beds. Heritage has medical surgical areas, Intensive Care and Intermediate Care, ER and OR services, rehab services, and psychiatric/behavioral health services. These services are divided into the following units within the hospital: Medical/Surgical West (MSW), Medical/Surgical East (MSE), Behavioral Health (BH), Post Anesthesia Care Unit/Recovery (PACU); Rehab, Intermediate Care Unit (IMU), Intensive Care Unit (ICU), Emergency Department (ER), and Operating Room/Anesthesia Department (OR). The pain clinic at Heritage is an outpatient clinic for patients who are being treated for chronic pain.

The corporate Human Resources Department is headed by Executive Vice President John Furman, who reports directly to President/CEO Fitzgerald. Under Furman are Corporate Director of Employee and Labor Relations Ed Frysinger and Corporate Director of Compensation and Benefits Dan Smorynski. Director of Employee and Labor Relations Verna Bastedo as well as the currently unfilled directors of staffing and human resources report to Frysinger, while a benefits manager, compensation manager, and pension analyst report to Smorynski. The corporate Human Resources Department has developed and issued standardized personnel forms for virtually all events and actions. It has promulgated uniform attendance, leave, and transfer policies and procedures. With the approval of senior management councils, it has formulated, and when necessary it revises, system-wide fringe benefit packages and wage ranges for every job classification. Local managers must use the prescribed forms and may not depart from the established policies, procedures, benefits, and wages. A common employee handbook summarizing these employment matters applies to workers at the four hospitals as well as other OHS facilities and OHI's home care division.

Director of Employee and Labor Relations Bastedo is OHI's labor contract negotiator. She also supervises human resource personnel at individual sites. Stationed at Annapolis are two human resource clerical employees, one

employment recruiter, and one human resource manager; at Heritage, two human resource clericals, a part-time employment recruiter, and a part-time human resource manager; at Seaway, two part-time human resource clericals, a part-time employment recruiter (shared with Heritage), and a part-time human resource manager (shared with Heritage); and at OHMC, three human resource clericals, five or six employment recruiters, and one human resource director. Bastedo assigns human resource professionals to perform tasks at facilities different from their home base when the need arises. On-site human resource staff members answer questions, direct inquiries, and implement but may not modify corporate employment policies and practices. Except for OHMC, which stores employee personnel files at a corporate office known as Village Plaza, the hospitals maintain their respective personnel files.

The corporate office of staffing coordinates the recruitment of nurses on a system-wide basis. OHS advertises all job openings throughout its system on OHI's web site and in various print and electronic media. It sends recruiters to job fairs. Nurse recruiters concentrate on assigned geographical areas, but will direct interested applicants to job openings at any site. After completing a standard application form, a job candidate receives an initial screening by a nurse recruiter. This involves a preliminary inquiry into minimum qualifications and a background criminal check. The recruiter sends all candidates who pass this minimum threshold to be interviewed by the clinical manager -- the on-site, first-line supervisory nurse -- into whose unit the candidates seek entry. The interviews conducted by the clinical manager explore the applicants' experience levels and clinical competence. An Employer witness testified that the final hiring choice is normally the product of consensus between the recruiter and clinical manager. As far as the record reveals, however, the recruiter does not participate in the clinical manager's interview regarding specific job qualifications. An Employer exhibit culled from one of many written procedures approved by a multi-site body called the Acute Care Nursing Operations Council states that the clinical manager selects the most qualified candidate and informs the nurse recruiter of the decision.

All employees covered by the handbook described above are subject to the same progressive disciplinary system. For minor infractions, the progression is counseling, a first and second written warning, a three- or five-day suspension, and finally termination. Major infractions may meet with more severe punishment. The nurse's on-site immediate supervisor undertakes the counseling and initiates the warnings. According to the handbook, suspension decisions originate with local nursing management, but must be reviewed by human resource personnel on site in order to assure consistent and equitable treatment. Terminations require the approval of a corporate vice president. The record does not reveal whether, or how often, corporate human resource officials countermand nursing managers'

suspension and discharge recommendations. All discipline is recorded on standard corrective action report forms and filed with the Human Resources Department.

The same employee handbook outlines a problem resolution mechanism for use at the hospitals and elsewhere. Steps one and two of the procedure are meetings between the aggrieved nurse and on-site nursing supervision. Step three involves a human resource representative who may be either based at the aggrieved nurse's hospital or imported from another site. Directors of Employee and Labor Relations Bastedo or Frysinger address grievances at step four. If the dispute arises out of a suspension or termination, impartial arbitration is available as a fifth and final internal step.

The chief administrative officer at Heritage is Rick Hillbom, who reports to Diedrich, the chief operating officer of OHI. Brenda Theisen, nursing site leader and director of patient care services at Heritage, reports to Hillbom regarding daily operations at Heritage. Theisen also reports to Barb Medvec, the chief nursing officer of OHS. The nursing site managers at Seaway, OHMC, and Annapolis also report to Medvec.⁵ Medvec and Diedrich do not work on site at the Heritage facility. As the nursing site leader at Heritage, Theisen is responsible for anything having to do with nursing care that is delivered by the hospital, although she does not directly supervise nurses on a day-to-day basis.

Reporting to Theisen at Heritage are clinical supervisors (also known as nurse supervisors or house supervisors) and clinical managers (also known as nurse managers).⁶ Clinical supervisors generally work on off shifts, such as afternoon shifts, midnights, holidays, and weekends. When they work they cover the entire hospital, nursing as well as every department within the hospital. Only one clinical supervisor works on a particular shift at a given time. The clinical supervisors do not spend too much time in a particular unit because they are overseeing the entire hospital. They spend considerable time in the ER, because they have to attend to any code (code blue, respiratory or cardiac arrest of a patient) that occurs. They also look at staffing for the next shift, call agencies or additional staff if needed, and document call-offs if someone is calling in sick. They also address any problems that may arise during their shift (i.e., fire alarm going off, flood.) When on duty, the clinical supervisor is the highest ranking administrative officer in the facility.

⁵ The parties stipulated at the hearing that Hillbom, Theisen, Medvec, and Deidrich are all statutory supervisors within the meaning of the Act based on their authority to discipline and independently direct employees.

⁶ The parties stipulated, and I find, that clinical supervisors and clinical managers are supervisors as defined in Section 2(11) of the Act based on their authority to discipline and independently direct employees.

Clinical managers are responsible for several units in distinct geographical areas within the hospital. Clinical managers are all RNs. They normally work the day shift, and they oversee the units that they are responsible for as far as developing a unit budget, finalizing schedules, and drafting schedules that have been submitted by the nursing staff. They work on development of policy for their units, and attend meetings, corporate as well as site meetings and department meetings. They are not regularly engaged in actual clinical work/nursing functions. They each have an office located within one of their units. They are on call 24 hours a day, and address the day-to-day issues and problems that arise within their units, assuming such problems cannot be addressed at a lower level. Clinical supervisors and clinical managers are salaried positions.

There are eight assistant clinical managers (also referred to as assistant nurse managers or ACMs) who report to the nurse managers.⁷ The ACMs are part of the management team and as such attend meetings, assist with schedules, and cover the clinical manager's responsibilities when the clinical manager is not in the building doing administrative functions. Not every unit has an ACM. The clinical managers direct the duties of the ACM. They work various shifts, determined by the clinical manager with whom they work. The position was created to enable the clinical manager to cover multiple units. The ACMs also handle day-to-day issues and problems if needed.

All registered nurses at the hospitals report directly to on-site nursing supervisors. With the recent advent of "service line" reporting configurations, however, the upper reach of supervisory hierarchy for nurses in certain specialties includes individuals who oversee that nursing specialty at more than one site. Nonetheless, the development of "service lines" has not erased the primacy of first-line supervision nor diminished the authority of the nursing site leader. A communication chain of command is contained in several written directives issued by the corporate Human Resources Department and approved by the Acute Care Nursing Operations Council. These policies specify that a nurse or charge nurse encountering any sort of patient, operational, or ethical problem is expected to notify a clinical manager or clinical nurse supervisor. The latter contacts the nursing site leader, who consults with the site administrator, service line leader, or risk manager as deemed necessary.⁸

⁷ The parties stipulated, and I find, that ACMs are supervisors as defined in Section 2(11) of the Act based on their authority to discipline and independently direct other employees.

⁸ Because there is some conflict among witnesses, and between testimony and exhibits, the record is less than crystalline regarding which specialties are "service lines." It is clear that out of a nursing staff at Annapolis of 232, 65 to 70 nurses are in "service lines."

Staffing and scheduling guidelines emanate from the corporate Human Resources Department. These precepts are further refined by the Acute Care Nursing Operations Council. The work schedule for nurses on each nursing unit must be posted for four weeks. The corporation has adopted what is considered a standard work day, and also offers nurses the option of working alternative schedules. Within these parameters, specific choices of unit shifts (days, evenings, midnights, or rotation) and hour patterns (4-hour, 8-hour, 10-hour, or 12-hour) are established by the unit's clinical manager. Requests for shift changes must be made in writing and submitted to the clinical manager. Employees may adjust their schedules by trading with colleagues, but all trades must be requested of and approved in advance by the clinical manager. The amounts of allotted vacation time, sick leave, and personal time are centrally prescribed, but specific requests for vacation time and other leave are submitted to and acted upon by the nurse's immediate site supervisor. In particular, the clinical manager sets the limit on the number of simultaneous vacations that she will allow.

OHS enforces an across-the-board policy forbidding mandatory overtime, but overtime will be scheduled and offered in emergencies. The clinical manager or clinical nurse supervisor determines whether an emergency exists, and all overtime must be approved in advance by those individuals. The corporation has a uniform attendance program that correlates discipline with the number of unexcused absences. The clinical manager has discretion to characterize an "emergency" absence as excused and an undocumented absence as unexcused.

Staffing guidelines are centrally determined, and are based on prescribed criteria such as patient census and acuity. The clinical nurse supervisor is responsible for assuring that adequate staff is available and for initiating the use of overtime, system or in-house flex pool nurses, or outside agency nurses to cover staffing shortages. Each hospital's nursing site leader maintains 24-hour accountability and availability to assure that appropriate staffing levels are continuous.

An inter-site nursing leadership council has devised detailed job descriptions for each nursing position. As noted above, each job has a set wage range from which site managers may not vary. A newly hired or transferred nurse is assigned a wage rate within the range based upon her level of experience, in accordance with a centrally determined grid. How years of experience for this purpose are counted or weighted is not disclosed in the record. The wage ranges for each job classification are uniform across the four acute-care hospitals.

All employees subject to the handbook receive periodic performance appraisals, prepared by immediate site supervisors on centrally prescribed forms. The supervisor assigns a numerical rating in specific areas, and the individual

ratings are converted, in accordance with a predetermined formula, into an overall score. As stated in the handbook, all employees with a final score of 100 or more are entitled to whatever across-the-board pay increase that the Employer chooses to implement. Any applicable pay increase will be the same for all eligible employees, regardless of the exact appraisal score.

The handbook states that OHS encourages inter-corporate voluntary job transfers as a way for employees to seek personal advancement. All employees with six months seniority in their present position, who have been free of disciplinary suspensions within the last two years, are eligible for a voluntary transfer. A nursing site leader may grant an exception to the six-month requirement. A nurse initiates a voluntary transfer by completing a transfer request form and submitting it to the Human Resources Department. The clinical manager of the unit being requested receives a copy of such request. As a position becomes available, the clinical manager interviews all applicants who meet the foregoing minimal requirements. Prior to making her decision, the clinical manager of the receiving unit will request background information from the transferring clinical manager. The receiving clinical manager makes the final selection, utilizing defined clinical criteria. A nurse who transfers to a new site may carry her accumulated sick and vacation time, but not unused holidays or personal days. Her length of service will follow her to the new site for the purpose of determining eligibility for service awards, vacation, sick time, and health benefits.

Nurses normally may not use their corporate seniority to "bump" into the position of a less senior nurse at a different site. Such bumping is theoretically permitted only in the case of a reduction of force *and* if the two nurses are in the same service line. Whether these twin conditions have ever been met so as to trigger an occasion of bumping was not disclosed in the record.⁹

During the 14.5 month period preceding the hearing in Case 7-RC-21970, 9 nurses permanently transferred from Annapolis to another OHS acute-care hospital, and 24 nurses permanently transferred to Annapolis. In relation to the 232-nurse complement at Annapolis, this is a transfer rate of 14%. Of the 24 in-coming transfers, 14 were occasioned by the closing of Beyer Hospital, an acute-care facility formerly part of Oakwood United Hospital, Inc. The record does not reveal the reason for the other Annapolis transfers, or whether they were voluntary or

⁹ The Employer's closure of the Annapolis-Westland behavioral health facility in 1997 affected 20 nurses. According to Verna Bastedo, their unionized status meant that OHS' bumping procedures did not apply. Nonetheless, 13 of the 20 nurses were offered jobs in OHS' acute-care hospitals. Obstetric units in Seaway and Beyer, a now defunct facility, also closed in recent years. There is testimony that affected nurses were absorbed into the corporate system and retained their seniority, but no indication that they displaced other nurses via bumping.

involuntary. If the Beyer closing did not occur during the selected time span, Annapolis' transfer rate would be 8%. During the same period, 24 nurses made permanent transfers among OHMC, Seaway, and Heritage. In addition, OHMC, Seaway, and Heritage also absorbed 23 nurses due to OHI's closing of Beyer Hospital. Excluding the Beyer transfers as non-recurring events yields a transfer rate among OHMC, Seaway, and Heritage of less than 1.5%.

During the 5-month period ending shortly before the hearing in Case 7-RC-21970, there were 7 temporary transfers of nurses from other OHS hospitals into Annapolis, and 63 temporary transfers of Annapolis nurses to other hospitals. The intervals of time spent working at the outside site varied; most exceeded eight hours. The preponderance of such temporary transfers was due to the assignment of flex pool staff, nurses who receive premium pay in exchange for working flexible schedules. The reasons for these temporary transfers were not explored at the hearing.

Other than the contact occasioned by the transfers described above, nurses from one site may encounter nurses from another during the corporate stage of new employee orientation. This program, which follows a uniform syllabus, takes place at a central corporate office and is attended by all newly hired nurses. Nurses also receive site-specific orientation upon being hired or transferred.

At Heritage, there is some variability with the staff nurse position depending on the department, but in general, there is one written job description that generally applies to RNs working throughout the hospital. The description states that RNs are responsible for providing direct care to patients utilizing the nursing process under general direction, guiding and supervising nursing personnel, collaborating with other health care professionals, and coordinating ancillary staff.

The clinical manager reviews the job description with the nurses when they have their annual performance appraisals. Among other things, the RNs are evaluated in their performance appraisals on their ability to act as a resource person for trouble-shooting, contributing to the professional growth of peers, colleagues, and others; precepting and mentoring; and ability to perform as a charge RN.

The type of work performed is basically what is dictated by their profession, based on the education and experience of an RN. They follow doctors orders, which are usually written instructions as to what type of treatment is needed, including administering blood tests, passing medications, and observing patients more closely. For every task performed by a nurse, there is a very specific policy and procedure in writing. However, long-time RNs generally do not need to refer to the policy and procedure manuals because of their experience, and many of the RNs working at Heritage have worked for the Employer for over 10 years.

The employees working with the RNs are typically employees such as mental health workers, who assist in the Behavioral Health Department; licensed practical nurses (LPNs), who are licensed to perform certain nursing tasks but not the full duties of an RN; nursing assistants, who generally work with and assist RNs with daily tasks; desk secretaries, who answer telephones, answer call lights from patients, and enter orders for patients; nurse externs, who are nursing students who have not yet graduated; graduate nurse externs, who are nursing students who have graduated but have not yet passed their exams or received their license; OR Techs and Surgical Techs, who assist staff nurses with the care of a patient undergoing surgical intervention, and ER techs and paramedics, who work in the Emergency Department to assist the staff working in the ER.¹⁰ The job descriptions of the majority of these positions state that they work under the direction of the RN. Most are also evaluated on whether they follow directions appropriately to meet the demands of the unit and the staff. The RNs are responsible for anyone else working under the RN level. This responsibility of "guiding and supervising nursing personnel" and/or "demonstrates effective leadership and professional development" is a criteria under which RNs are evaluated during their performance appraisals.

RNs may assign mental health workers, nursing assistants, techs, or other less skilled employees to do certain tasks that are within their ability. For example, they may assign a mental health worker to work with a group of patients, or they may instruct a nurse assistant to give a patient a bath, walk a patient to the bathroom, or give a patient a meal. They assign these tasks to the nurse assistants because that is what a nursing assistant's job is - to assist the staff. If something more important comes up, the RN may interrupt that task and assign the nurse assistant to something else. Nursing assistants and techs are also aware of certain jobs they can do and will take it upon themselves to do these jobs, without first being told. It would be insubordination if a nurse assistant refused to listen to the RN, and the RN could go to a superior to intervene. However, it could be proper for an assistant to refuse a task for good reason, such as if they were busy on a different assignment. Regardless, no situation has arisen where an assistant or other worker refused to perform a task. If this did occur, RNs do not believe that they have the authority to do very much about it other than going to the clinical manager, as they have no role in disciplining employees.

The RNs do not rotate shifts. They work straight shifts; day, afternoon, or midnight, or 12-hour shifts, which are ordinarily day shifts (7:00 a.m. to 7:00 p.m.) or midnight shifts (7:00 p.m. to 7:00 a.m.). However, they do take turns rotating the

¹⁰ The nursing assistants are the only employees mentioned in this group that are represented by a union, Local 79.

responsibility of charge nurse. On every shift in each unit, except the pain clinic, there is one RN assigned to work as a charge nurse. At times, however, assistant clinical managers have filled in as charge nurses. In particular, in late 2001 assistant managers filled in as charge nurses to decrease agency nurse hours.

Rotating charges are individuals who occasionally take charge nurse responsibilities in a unit. The frequency with which it happens depends on the size of the unit and the number of RNs that occasionally rotate. A permanent charge is a person who has requested to and agreed to be in permanent charge; each time they work, they work as a charge nurse. The duties of a charge nurse, whether rotating or permanent, are the same. RNs are paid hourly. They earn \$1.50 more per hour when they are working as a charge nurse.

In the IMC Department, if the assistant nurse manager is not there to take charge, they rotate the responsibility of charge nurse. Sometimes it is assigned by the clinical manager on the schedule, and sometimes it is not. If it is not assigned, then they take turns. RN Coffee testified that she is a charge nurse approximately one to two times during a two-week schedule.¹¹ Similarly, RN Welch testified that her work schedule in the ER indicates when she is assigned to the charge nurse responsibility. The schedules come out in a four-week time frame. As with Coffee, in a two-week time frame, she is usually in charge once or twice.

RNs must have at least one year of nursing experience to act as charge nurses. RNs learn the responsibilities of a charge nurse through their education, and by initially working with a preceptor, or mentor. Preceptors will work along with the RNs as charge nurses until the RNs are able to perform the job on their own.

Some RNs choose not to be in charge at all and there is not necessarily a permanent charge on each unit. However, a review of Employer's Exhibit 12 reflects that a majority of RNs, with the exception of those working at the Pain Clinic and in the Operating Room, take turns rotating as charge nurse. It appears from the record that most of the RNs who are not rotating are newer employees who are not yet ready to take on the charge nurse responsibilities. Also shown by Exhibit 12 is that only approximately 11 nurses are permanent charges.¹² In the Behavioral Health Unit, every RN is a rotating charge or a permanent charge. Where there is a permanent charge on a particular shift, the rotating charges on that shift take turns acting as a charge nurse on the days when the permanent charge is not working.

¹¹ Coffee works part-time, which is five days out of every two weeks. As such, she is charge nurse approximately two out of every five days that she works.

¹² The majority of the permanent charges work in the Behavioral Health Unit.

Charge nurses are responsible for overseeing the unit for the shift that they are working, with the staff who are working the unit that day. They do the assignments of all the staff that are working on that shift. They monitor in general all the patients that are in the unit that day, and meet with physicians if a physician has an issue with a nurse or with a patient. They also meet with patients or family members who have a complaint. Some responsibilities vary within each unit. If a variance occurs during a shift, such as a medication error, patient fall, or any other incident, a form called a "quality assessment report" is filled out. The charge nurse is responsible for following up with the incident by examining the patient, and signing the report as the "person in charge." If necessary, the charge nurse will call a physician to evaluate the patient.

RNs are sometimes pulled to work in other units, but not if they are assigned to work on charge duty. If it is a nurse's turn to be pulled, and she is on charge duty, she will stay on that shift and go the next time. When RNs are pulled to work in other units, it usually happens at the start of the shift. The charge nurse is informed that a nurse is needed in another department, and is given the names of the nurses who are to be pulled by the clinical supervisor from the previous shift. Charge nurses can also be called in the middle of the shift – a supervisor may inform the charge nurse that one of her nurses is needed in another unit. The charge nurse cannot refuse that request. If the charge nurse refused to send someone, there would be disciplinary action. The charge nurse does not assign employees to shifts; that is done by a staffing office. When the charge nurse comes in, she is handed a list (prepared by the supervisor on the previous shift) of the nurses who are supposed to be working that day on her shift. If nurses on the list do not show up, the charge nurse calls the staffing office to find out where that person is.

OHS has a policy for the assignment of nursing personnel to provide adequate numbers of licensed staff and other personnel to deliver care to patients. Under this policy, assignments are to be made in accordance with the patient's need. In making assignments, the charge nurse must determine the acuity of the patient and determine the level of skill required to care for the patient – i.e., RNs can perform certain tasks that cannot be performed by LPNs, etc. Level of experience of the nurse, determining which nurses work well together as a team, as well as other activities that a particular nurse may also be responsible for, are also considered. On occasion, assignments will be changed mid-shift; for example, if there is a change in a patient's condition such that different care is warranted. The charge nurse also assigns nursing assistants or mental health workers either to particular patients or to work alongside specific RNs. After receiving their general assignment, the RN and/or the charge nurse may assign them more specific tasks such as giving a patient a bath, etc. Charge nurses are also responsible for assigning breaks and lunches to other employees. However, they do this by asking the other

nurses when they would like to take their break, and their main goal in assigning breaks is to make sure the unit is covered at all times.

At times RNs may complain about particular assignments. The charge nurse can re-evaluate and make changes in assignments if appropriate. This could occur if a patient requires more work than expected, or if a patient's condition changes which requires more treatment or attention. However, the record does not indicate any instances of a serious conflict based on job assignments. Furthermore, RNs usually work together to help each other out, as a common courtesy of their profession. If RNs need help with a patient, they may go directly to another nurse and ask rather than going to the charge nurse. Many of the tasks handled by the charge nurse, including complaints of family members, can be handled by any RN. One RN testified that she does not interact any differently with other RNs on staff when she is a charge nurse compared to when she is not.

Some charge nurses may take patient assignments in addition to their other responsibilities. Whether or not a charge nurse takes an assignments typically depends on what department they work in and on what shift they work. Charge nurses on each shift are responsible for deciding whether or not they take assignments. Charge nurses frequently do take patients, although they will often take fewer patients than the other staff nurses on duty.

The assignment of staff nurses to patients is much more perfunctory in practice than the Employer's written assignment policy indicates. The assignment of work is generally rotated, or based on where a person worked the previous day. When making assignments as a charge nurse, reference is made to a staffing sheet showing where everyone worked the day before. It usually takes only a few minutes to do the assignments. There was testimony that the main responsibility of the charge nurses is to be familiar with what is going on in their particular units, and to basically be the go-to person for questions or issues that arise. For example in the ER, the charge nurse has to answer to the clinical supervisor's or manager's inquiries about whether there will be patient admissions. This will determine whether extra staffing is needed for a particular unit, such as ICU.

When the nurses arrive for their shifts in the IMU, they all listen to the report from the charge nurse of the previous shift. Then the charge nurse makes the assignments by asking who knows which patients have the highest acuity (these patients are referred to as the "completes"). They get a slip from the staffing office showing who is supposed to be there that day. The charge nurse then makes out the assignments. First, the completes are divided up evenly. After that, they look at who was there the day before, and try and give them the same assignment they had in order to maintain continuity. In IMU, nurse assistants make out their own assignments.

The charge nurse in IMU is also responsible for assigning beds to new patients or transfers from ICU. When determining where to assign the new patient as far as the staff is concerned, the charge nurse will go by who did an admission the day before – or, who currently has three patients instead of four. If necessary, the charge nurse may assign the patient to herself. If everyone had a full load, she would go to the manager. It also becomes necessary to reassign patients to different staff, if, for example, there is a personality conflict between a nurse and a patient. This could be handled by asking another nurse if she would take the patient. It is questionable whether the charge nurse has the authority to force another nurse to take another patient.

Generally, it is the clinical manager who hires, fires, and handles conflicts within the unit. They also handle performance evaluations, finalize schedules, and handle staffing issues and patient complaints. The assistant manager also does these things. Charge nurses do not make the decision to hold someone past the end of their shift if they are short staffed, nor do they authorize overtime. Charge nurses can be, and have been, disciplined by clinical managers.

Congress instructed the Board to make unit findings so as “to assure to employees the fullest freedom in exercising the rights guaranteed by this Act.” 29 U.S.C. §159(b). It is axiomatic that nothing in the Act requires a bargaining unit to be the *only*, or the *ultimate*, or the *most appropriate* grouping. *Overnite Transportation Co.*, 322 NLRB 723 (1996); *Capital Bakers*, 168 NLRB 904, 905 (1967); *Morand Bros. Beverage Co.*, 91 NLRB 409 (1950), *enfd.* 190 F.2d 576 (7th Cir. 1951). A union need not seek representation in the most comprehensive grouping of employees unless an appropriate unit compatible with the union’s request does not exist. *Purity Food Stores*, 160 NLRB 651 (1966); *P. Ballantine & Sons*, 141 NLRB 1103 (1963). A union’s desire is always a relevant, although not a dispositive, consideration. *E. H. Koester Bakery & Co.*, 136 NLRB 1006 (1962).

A single facility of a multi-location employer is a presumptively appropriate unit. *Hegins Corp.*, 255 NLRB 160 (1981). The Board, with court approval, uses the same single-facility presumption in fashioning health care units. *Manor Healthcare Corp.*, 285 NLRB 224 (1987); *Presbyterian University Hospital v. NLRB*, 88 F.3d 1300, 1309 (3rd Cir. 1996); *Staten Island University Hospital v. NLRB*, 24 F.3d 450, 456-467 (2nd Cir. 1994).

Manor Healthcare mandates consideration of traditional factors in deciding whether the presumption has been overcome. Such factors are geographic proximity, bargaining history, employee interchange and transfer, functional integration, administrative centralization, and common supervision. Thus, the presumption is normally overcome only if employees from the single location have

been blended into a wider unit by bargaining history, or if the single location has been so integrated with a wider group as to cause it to lose its separate identity. *Heritage Park Health Care Center*, 324 NLRB 447, 451 (1997), enf. 159 F.3d 1346 (2nd Cir. 1998); *Passavant Retirement & Health Center*, 313 NLRB 1216 (1994); see also *Centurion Auto Transport*, 329 NLRB No. 42 (1999). The presumption may also be rebutted in the health care setting by a showing that approval of a single-facility unit will increase the kinds of disruptions to continuity of patient care that Congress sought to prevent in cautioning against proliferation of units in the health care industry. *Mercywood Health Building*, 287 NLRB 1114, 1116 (1988), enf. denied on other grounds sub. nom. *NLRB v. Catherine McAuley Health Center*, 885 F.2d 341 (6th Cir. 1989).

The Employer has undertaken a number of measures to streamline its enterprises. This has resulted in centralization of many administrative functions, including marketing, purchasing, recruitment, payroll, and human resources. Wages, benefits, and disciplinary procedures exhibit a high degree of uniformity. The advent of service lines affects the reporting structure by making certain mid- and high- level nursing supervisors responsible for coordinating nursing services at more than one facility.

Nonetheless, each nurse at Heritage reports to a supervisor on site, and on-site management still exercises significant autonomy over the Heritage nurses' work lives. Clinical managers control work schedules, choice of shifts, and hours. They grant or deny leave requests, determine how many vacations will be permitted at a time, and decide whether overtime will be worked. Management at Heritage interviews and selects new hires and transferees from pools of eligible nurses. A clinical manager has some discretion in the classifying of an absence as excused or unexcused.

Heritage management and supervisory personnel initiate all disciplinary actions, and, as far as the record reveals, take conclusive unilateral action with respect to counseling and written warnings. Similarly, Heritage management has the authority to resolve grievances at the first two steps of the dispute resolution procedure. A nurse's job performance appraisal by her nurse manager determines her eligibility for any across-the-board wage increase. When professional, operational, and ethical problems arise, nurses are specifically instructed to follow the chain of command that originates at the first level of nursing management at the site, and travel through the site's hierarchy to the nursing site leader.

The foregoing recital demonstrates that within the Employer's framework, Heritage nurse management retains significant authority. The presence of local control is a decisive factor and overcomes even strong evidence of centralization. *NLRB v. HeartShare Human Services of New York, Inc.*, 108 F.3d 467 (2nd Cir.

1997), enforcing 317 NLRB 611 (1995) (finding single facility appropriate). In *RB Associates*, 324 NLRB 874 (1997), the Board, relying in part on the existence of local supervision, found a single hotel unit to be appropriate, despite the close proximity of other hotels; common personnel policies, handbook, benefits, rules, and regulations; central hiring; commonly conducted orientation; intercession of a corporate human resource director in hiring, discipline, and performance evaluations; identical employee skills and functions; and open transfers without loss of benefits or seniority. See also *Children's Hospital of San Francisco*, 312 NLRB 920 (1993), enfd. sub. nom. *California Pacific Medical Center v. NLRB*, 87 F.3d 304 (9th Cir. 1996).

There is no relevant bargaining history in this case militating against the appropriateness of a single-facility finding. The evidence does not show, nor does OHI contend, that a single-facility unit finding will threaten the continuity of patient care. *Hartford Hospital*, 318 NLRB 183, 193 (1995), enfd. 101 F.3d 108 (2nd Cir. 1996).

The evidence of interchange, as introduced in Case 7-RC-21970, is limited. The majority of permanent transfers in the period under examination was caused by the closure of an acute-care hospital. The remaining permanent transfers were statistically negligible in the overall unit sought by the Employer. Many more temporary transfers were attributable to the use of flex pool nurses than to migration of the stationary nursing corps.

I find the cases relied upon by the Employer to be distinguishable. In *West Jersey Health System*, 292 NLRB 749 (1989), the Board had a concern, absent here, that unit fragmentation would adversely affect patient care services. The record in *West Jersey* also demonstrated considerably more employee interchange, with 147 permanent transfers in a 14-month period, regular temporary rotation of unit employees to other facilities, and the availability of seniority bumping rights.¹³ In *Presbyterian/St. Luke's Medical Center*, 289 NLRB 249 (1988), the Board found that a "significant number" of transfers had occurred and that physicians need not make separate applications, as they do here, to be admitted to practice. In *Montefiore Hospital*, 261 NLRB 569 (1982), neither party sought a single-facility unit, and the Board's task was to delineate an appropriate unit among competing multi-location groupings.

The Employer has adduced evidence tending to show that a unit comprised of its four acute-care hospitals may be appropriate. However, that a wider unit may

¹³ In *West Jersey*, employees could transfer by exercising bumping rights. At the Employer, no voluntary transfers may be accomplished by bumping. Rather, seniority may be exercised on an inter-site basis only within the same service line during a reduction in force.

be appropriate does not imply that a narrower one is inappropriate. *Children's Hospital of San Francisco*, supra at 928. The Employer bears the burden of establishing that consolidation and centralization have destroyed Heritage's identity. For the reasons discussed above and based upon the entire record, I find that the Employer has not met that burden.

Section 2(3) of the Act excludes from the definition of the term "employee" "any individual employed as a supervisor." Section 2(11) of the Act defines a "supervisor" as:

any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not merely of a routine or clerical nature, but requires the use of independent judgment.

Section 2(11) is to be interpreted in the disjunctive and the possession of any one of the authorities listed in that section places the employee invested with this authority in the supervisory class. *Ohio Power Co. v. NLRB*, 176 F.2d 385 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949); *Allen Services Co.*, 314 NLRB 1060 (1994).

On May 29, 2001, the Supreme Court issued its decision in *NLRB v Kentucky River Community Care*, 532 U.S. 706, 121 S.Ct. 1861, 167 LRRM 2164 (2001), wherein the Court upheld the Board's longstanding rule that the burden of proving Section 2(11) supervisory status rests with the party asserting it. See *Ohio Masonic Home*, 295 NLRB 390, 393 fn.7 (1989); *Bowen of Houston, Inc.*, 280 NLRB 1222, 1223 (1986). However, the Court rejected the Board's interpretation of "independent judgment" in Section 2(11)'s test for supervisory status, i.e., that registered nurses will not be deemed to have used "independent judgment" when they exercise "ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards." 121 S.Ct. at 1863. Although the Court found the Board's interpretation of "independent judgment" in this respect to be inconsistent with the Act, it recognized that it is within the Board's discretion to determine, within reason, what scope or degree of "independent judgment" meets the statutory threshold. See *Beverly Health & Rehabilitation Services*, 335 NLRB No. 54 (Aug. 27, 2001). However, the Court did agree with the Board in that the term "independent judgment" is ambiguous as to the *degree* of discretion required for supervisory status and that such degree of judgment "that might ordinarily be required to conduct a particular task may be reduced below the statutory threshold by detailed orders and

regulations issued by the employer.” 121 S.Ct. at 1867. In discussing the tension in the Act between the Section 2(11) definition of supervisors and the Section 2(12) definition of professionals, the Court also left open the question of the interpretation of the Section 2(11) supervisory function of “responsible direction,” noting the possibility of “distinguishing employees who direct the manner of others’ performance of discrete tasks from employees who direct other employees.” 121 S.Ct. at 1871. See *Majestic Star Casino*, 335 NLRB No. 36 (Aug. 27, 2001).

For instance, direction as to a specific and discrete task falls below the supervisory threshold if the use of independent judgment and discretion is circumscribed by the superior’s standing orders and the employer’s operating regulations, which require the individuals to contact a superior when anything unusual occurs or when problems occur. *Dynamic Science, Inc.*, 334 NLRB No. 56 (June 27, 2001); *Chevron Shipping Co.*, 317 NLRB 379, 381 (1995).

In the instant case, there is no evidence that the RNs, whether acting as a charge nurse or a staff nurse, have independent authority with respect to the hire, promotion, demotion, layoff, recall, reward, or discharge of employees. They do not make staffing decisions, and they do not authorize overtime. The Employer rests its claim of supervisory authority primarily upon other indicia, i.e., the alleged ability to adjust grievances, and the alleged authority to assign and direct the work of less skilled employees.

There is no evidence that the charge nurses are empowered to adjust any formal employee grievances. Charge nurses are not part of the grievance process outlined in the Local 79 contract covering other members of the nursing staff. For the most part, complaints or disputes brought by the nursing staff to the charge nurse that cannot be resolved quickly in an informal manner are relayed to supervision. See *Ken-Crest Services*, 335 NLRB No. 63 (Aug. 27, 2001). Furthermore, there is a lack of evidence that RNs have actually adjusted grievances. The limited authority exercised by charge nurses to resolve interpersonal conflicts among employees does not confer supervisory status. *St. Francis Medical Center-West*, 323 NLRB 1046, 1047-48 (1997).

For every task performed by an RN, there is a very specific policy and procedure in writing. These procedures are available for review by the RNs in their work area; however, some of the more experienced RNs do not need to refer to the policies and procedures on a regular basis due to their length of experience. The limited authority of RNs to assign discrete tasks to less skilled employees, based on doctor’s orders, hospital policy and procedures or standing orders, or what is dictated by their profession, does not require the use of independent judgment in the direction of other employees. *Ferguson Electric Co.*, 335 NLRB No. 15 (Aug. 24,

2001). The RNs do not evaluate the work of the less skilled employees or ensure that they have completed a task or done so correctly.

The Employer asserts that charge nurses exercise independent judgment when they assign staff nurses to particular patients or beds, by matching the level of experience of the employee with the level of acuity of the patient. However, the Employer has a very detailed written policy for the assignment of patients by charge nurses or assistant clinical managers. Pursuant to this policy, it is the responsibility of clinical managers or assistant clinical managers to ensure adequate staffing levels, and the composition of staff as to skill level when it comes to caring for the patients in a particular unit. Direction as to specific and discrete tasks and even the assignment of employees detailing when and where they are to carry out their duties falls below the supervisory threshold if the use of independent judgment and discretion is supervised by the superior's standing orders and the employer's operating regulations. *Dynamic Science, Inc.*, 334 NLRB No. 56 (June 27, 2001); *Chevron Shipping Co.*, 317 NLRB 379, 381 (1995). Furthermore, the weight of the evidence suggests that in practice, the assignments are routine in nature, and are based mainly on principles of fairness and the even distribution of work. *Byers Engineering Corp.*, 324 NLRB 740 (1997); *Providence Hospital*, supra; *Ohio Masonic Home*, supra. For the most part, the schedule is based on the schedule from the previous day, and providing continuity for the patients. Finally, the RNs work together to resolve any problems with patient assignments, based on the very nature of the rotating charge nurse position. A charge nurse assigning a patient to a staff nurse one day, can the next day be assigned a patient from that same staff nurse, when the roles are reversed. A charge nurse also assigns break times for other employees. However, the charge nurse generally sets up the break times in order to ensure coverage on the floor, and receives input from the nursing staff as to when they would like to take their break.

The Employer submits that if RNs are not supervisors, the ratio of nursing supervisors to nursing staff would be preposterous. However, on the other hand, if all staff nurses are found to be supervisors, the ratio of nursing supervisors to nursing staff would be one supervisor for less than every two employees. *Naples Community Hospital*, 318 NLRB 272 (1995); *Essbar Equipment Co.*, 315 NLRB 461 (1994); *Beverly California Corp. v. NLRB*, 970 F.2d 1548, 1550 fn. 3 (6th Cir. 1992). Furthermore, clinical supervisors, assistant clinical managers and/or clinical managers are present or on call 24 hours a day to handle any problems that may arise. Consequently, I find that the RN staff nurses/charge nurses are not statutory supervisors.¹⁴

¹⁴ Due to the rotating nature of the charge nurse position, the frequency with which each RN serves as a charge nurse varies. Some are permanent charges; some spend nearly half of their time as a charge nurse, and some are hardly ever in charge. Because I find that the charge nurses, whether permanent or rotating, do

5. For the above reasons, and based on the record as a whole, the following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within Section 9(b) of the Act.

All full-time, regular part-time contingent and in-house flex registered nurses at the Employer's facility, Oakwood Heritage Center, located in Taylor, Michigan; but excluding all physicians, technical employees, other professionals, business office clericals, support service employees, skilled maintenance employees, confidential employees, director of surgical services, nursing site leader, clinical nurse supervisor, assistant clinical manager, clinical manager, nurse externs, graduate nurse externs, and all managers, supervisors, and guards as defined in the Act.

Those eligible shall vote as set forth in the attached Direction of Election.

Dated at Detroit, Michigan this 4th day of February, 2002.

(SEAL)

/s/ Stephen M. Glasser

Stephen M. Glasser, Acting Regional Director
National Labor Relations Board, Seventh Region
Patrick V. McNamara Federal Building
477 Michigan Avenue, Room 300
Detroit, Michigan 48226

177-8520-0000
177-8560-1000
177-8560-1500
440-1700

not exercise statutory supervisory authority, the frequency with which a particular nurse may serve as a charge nurse is not controlling.

Participants

Docket and Order

07-RC-22141

Oakwood Healthcare, Inc.

Employer MR

WILLIAM M THACKER ESQ
CLAIRE S HARRISON ESQ
DYKEMA GOSSETT PLLC

315 EAST EISENHOWER PARKWAY
SUITE 100
ANN ARBOR, MI 48108

Tel: (734) 214-7660
Fax: (734) 214-7696

Employer

OAKWOOD HERITAGE HOSPITAL
ATTN RICH HILLBOM

1000 TELEGRAPH ROAD

TAYLOR, MI 48180

Tel:
Fax:

Petitioner MR

INTERNATIONAL UNION UAW
ATTN BLAIR SIMMONS ESQ

8000 EAST JEFFERSON AVNEUE

DETROIT, MI 48214

Tel: 313-926-5000
Fax: 313-823-6016

Petitioner (Union)

JAN SCHULZ

22451 CHERRY HILL

DEARGORN, MI 48124

Tel:
Fax:
